2011

Open Enrollment Booklet

The Year 2011 RETIREE Open Enrollment Period Runs From OCTOBER 11, 2010 through OCTOBER 29, 2010

City of Milwaukee

Retirees

Employes' Retirement System

789 North Water Street
Suite 300
Milwaukee, WI 53202
(414) 286-3557
www.cmers.com

See Health Plan choices inside.
All City enrollees with Medicare are automatically enrolled in the DeanCareRx Medicare D Drug Plan.

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DISCLAIMER:

Receiving this booklet does not necessarily imply you are eligible for City health coverage. Only persons eligible under labor contract provisions, Common Council resolutions, or COBRA may enroll. In making these various plans available, the City of Milwaukee is not endorsing the selection of a particular plan or the level of benefits or quality of care offered by a particular plan. It is the responsibility of the retiree to carefully review the plan and to make a decision based on this review. This material was prepared and sent with the cooperation of the City's health plans.

City of Milwaukee

Department of Employee Relations

October 1, 2010

Dear City of Milwaukee Retirees:

Medicare retirees will again have the choice of three plans for 2011 – the City Basic Plan administered by Anthem (Basic Plan), the UnitedHealthcare Choice HMO plan (Choice Plan) and the UnitedHealthcare Group Medicare Advantage (PPO) Plan *(replaces the SecureHorizons MedicareDirect(PFFS) Retiree Plan)*. The City provides a 25% subsidy for these plans and the members pay 75% of the cost. All three plans include the DeanCareRx Medicare D plan. Monthly Premiums for one Medicare Retiree with the Basic Plan is $324.23 while one with the UnitedHealthcare PPO Plan is $304.47. The increase in the Basic Plan in 2011 is based on utilization of services and increases in medical and drug costs. Rates for the Choice Plan for one Medicare Retiree will be $346.32 and have been reduced in 2011. Medicare retirees should review the benefits for each of the plans in this booklet.

For those retirees **WITHOUT MEDICARE**, your benefits and monthly premiums are controlled by labor contracts. The cost in 2011 for the UnitedHealthcare Choice plan for family coverage without medicare is greater than the Basic Plan cost for the same family coverage. The Basic Plan family cost for a retiree without Medicare in 2011 is $2486 and the UnitedHealthcare Choice Plan cost for coverage in 2011 is $2873.

For Fire and Police retirees under 65 with family coverage and sufficient unused sick leave for the maximum City contribution of 100% of the Basic Plan family, there is no cost for the Basic Plan. You will pay $387 for UnitedHealthcare Choice family coverage, which is the difference between the cost of the UnitedHealthcare Choice family plan of $2873 and the City contribution of 100% of the Basic Plan family cost of $2486. Fire and Police retirees with less unused sick leave balances will likely pay more for your health plan selection for either a family or single plan selection as the percentage contributed by the City towards the cost of your health plan selection will also decrease.

For general City employees who retired prior to January 1, 2005, the labor contract states the City will contribute up to 100% of the Basic Plan single or Basic Plan family premium towards the cost of the health plan of your choice. For these general city employees choosing UnitedHealthcare Choice family plan, the cost will be $387 and $0 for Basic Plan family. For employees selecting single coverage in either the Basic Plan or UnitedHealthcare Choice plan, the cost will be $0.

Below are some of the changes that are likely to affect City retirees. These features have been implemented to improve quality for all, to provide coverage for those without coverage, and to limit those criteria that often left

persons without any insurance:

- Provide insurance for your dependent child up to the end of the year they turn 26 without regard to their student status or their dependent status;
- Remove all lifetime maximums on the Basic and HMO plans;
- Remove any annual limits for behavior health benefits, as long as the services are medically necessary; and
- Provide additional benefits to Medicare retirees with a Medicare D plan such as the DeanCareRx.Plan.

Please read your Open Enrollment Booklet carefully and see the information on the Retiree Open Enrollment Fairs on page 6. If you have questions for the providers, their phone numbers are on page 33. Additionally, please see page 12 for information on the new UnitedHealthcare PPO health plan replacing SecureHorizons MedicareDirect (PFFS) Plan.

Sincerely,

Michael Brady
Employee Benefits Director

Retiree Open Enrollment
General Information

The Annual RETIREE Open Enrollment will take place from October 11, 2010 through October 29, 2010

This booklet includes information for all City of Milwaukee Retirees.

- Some information is specific for **Medicare retirees**, some for **non-Medicare retirees**.
- Some information is specific for retirees enrolled in the **Basic Plan**, some information for those enrolled in the **UnitedHealthcare** (**UHC) Choice Plan (Choice Plan)**, some for those with the new **UnitedHealthcare Group Medicare Advantage (PPO) Plan** (*replaces the SecureHorizons® MedicareDirect℠ Private Fee-For-Service retiree plan))*.
- There is also information about the City's **Prescription Benefit Manager (PBM)**, whether you are in the Basic Plan, the Choice Plan or the PPO Plan, or whether you are a Medicare retiree or non-Medicare retiree. This year Navitus Health Solutions will continue to administer the PBM program for all non-medicare retirees, and DeanCareRx will administer the PBM for all Medicare retirees and any Medicare Spouse and Dependents.

We hope the information is helpful to you in making critical decisions regarding your health plan choices as a City of Milwaukee retiree. This is your only opportunity during the calendar year to make a change to your health plan for 2011.

In 2011 the City is providing the following health plans for Retirees:

- ***The Basic Plan*** administered by Anthem Blue Cross Blue Shield, the City's self-funded plan, with a national network of providers.
- ***The Choice Plan,*** a comprehensive insured plan with a national network of providers.
- ***The UnitedHealthcare PPO Plan***, a national PPO plan with all Medicare providers available to "one person with Medicare" or "two persons with Medicare" only.

In 2011 the City is using two Prescription Drug Plans.

- Navitus Health Solutions for retirees **without** Medicare.
- DeanCareRx Medicare D plan is primary for retirees, spouses and dependents **with** Medicare.
  Both drug plans have some drugs that require pre-authorizations.

You <u>DO NOT</u> have to complete a health enrollment form if you do not wish to change your health plan for 2011.

If you are enrolled in the SecureHorizons Medicare Direct Plan in 2010, you will automatically be transitioned to the UnitedHealthcare PPO Plan in 2011.

- You **NEED TO COMPLETE** a Health Enrollment Form if you are doing any of the following:
  - In the Basic Plan and changing to the Choice Plan or UnitedHealthcare PPO.
  - In the Choice Plan and changing to the Basic Plan or UnitedHealthcare PPO.
  - In the SecureHorizon Plan and changing to the Basic Plan or Choice Plan.

If you are making a change to your health plan during Open Enrollment, you will receive a new ID card.

Be sure to contact your health plan or doctor's office to make sure your doctors and preferred hospital are continuing with the plan you select for 2011. All retiree enrollment forms **must be in the ERS office on or before 4:45 pm Friday, October 29, 2010.**

Open Enrollment Information Fairs

Retiree Open Enrollment Fair

The City will hold Five (5) Open Enrollment Fairs that are open to all City employees and retirees. All health plans will be at these five. The schedule is listed below.

Thursday, October 7 – 1:00 p.m. to 6:00 p.m. ..... Wilson Park Senior Center
..... 2601 West Howard Avenue

Thursday, October 14 – 9:00 a.m. to 1:00 p.m. ..... City Hall Rotunda
..... 200 East Wells Street

Thursday, October 14 – 3:30 to 6:00 p.m. ..... Fire and Police Academy
..... 6680 North Teutonia Avenue

Thursday, October 21 – 12:00 p.m. to 4:00 p.m..... Bayview Public Library
..... 2566 South Kinnickinnic Avenue

Tuesday, October 26 – 11:00 a.m. to 4:00 p.m..... DPW Field Headquarters
..... 3850 North 35th Street
..... Room 168

For all Medicare Retirees interested in the United Healthcare Group Medicare Advantage (PPO) Plan *(replacese the SecureHorizons® MedicareDirectSM)*, **there will be two extra health fairs:**

Tuesday, October 12 – 10:00 a.m. to 11:30 a.m..... ERS
..... 789 N. Water St.
..... 4th Floor Conference Rm

Wednesday, October 20 – 10:00 am to 11:30 a.m. ..... ERS
..... 789 N. Water St.
..... 4th Floor Conference Rm

Please note that the ERS conference room has maximum capacity of 50 persons.

NOTE:
When this booklet was printed the City had not established Health/Dental terms for the year 2011 with all employee groups. As a result the employee and retiree contribution levels for active and newly retired may be affected.

RETIREE HEALTH PLANS - YEAR 2011

City of Milwaukee Retiree BASIC PLAN

Administered by Anthem Blue Cross Blue Shield - www.Anthem.com 1-866-926-7789

The Basic Plan is available to all retirees, those with Medicare and those without Medicare. The benefits for this plan are detailed later in this booklet and in a Master Plan Document available on-line. The Basic Plan allows members to see any provider. There is an Anthem network that will protect you from getting balance billed by a non-network provider. For more information about the Anthem network, call Anthem.

The Basic Plan is designed to provide in-patient hospital benefits, medical/surgical benefits and major medical benefits. All non-medicare Anthem members have the benefit of the Utilization Review/Case Management (UR/CM) program. If you have questions contact Anthem at 1-866-926-7789.

Please note that the benefits for the Basic Plan, the Choice Plan or the UnitedHealthcare PPO Plan are not the same.

BASIC PLAN HOSPITAL BENEFITS

- Hospital benefits are available for inpatient care (semi-private room) for each period of disability.
- All medically necessary in-patient hospital services, equipment, medications and supplies are provided.
- In-patient care is also provided for treatment of mental health and substance abuse.
- Outpatient coverage is provided for first aid emergency services, medical emergencies and treatment of mental health and substance abuse.

HEALTH IMPROVEMENT PLAN (Disease Management)

Anthem offers a disease management program called the Health Improvement Plan (HIP). HIP offers an innovative, multidisciplinary approach to helping retirees manage their asthma, congestive heart failure and diabetes. Program participants have experienced an increased quality of life and declined use of costly services. Through Health Coaching the goals are to reduce patient anxieties about their condition and help them better manage their condition; identify areas of need and enhance appropriate use of the healthcare system, and reduce the need for emergency room visits and/or lengthy hospitalizations.

Eligible participants are identified through routine reviews of submitted diagnosis and pharmacy codes in our claims system and then categorized as either high risk or low risk for one of the above three conditions. Retirees or their dependents may also be referred to the program through a hospital discharge report, a Physician or medical group referral, Case Management or by a self-referral by calling 1-866-387-8827**.** PARTICIPATION IS ALWAYS UP TO THE MEMBER.

MAJOR MEDICAL

Covers 80% of the cost of most routine medical expenses (if medically necessary), after the deductible of $50.00 per retiree, $150.00 per family maximum has been satisfied. Deductible will continue to accrue for three and more dependents until the third deductible has been reached. Coverage includes office visits and prescription drugs, as well as ambulance charges, private duty nursing, medical supplies, and a number of other items.

UTILIZATION REVIEW/CASE MANAGEMENT (UR/CM)

The UR/CM Program administered by Anthem Open Access, is a cooperative effort by the City and its unions to improve the efficiency of health care delivery while maintaining the quality of care. This program does not shift health care costs to retirees or reduce benefits. It does use medical resources in the most cost-effective manner by discouraging unnecessary hospitalizations and surgeries. Also included is a medical information service that can provide information about a wide variety of medical-related subjects. If you have questions, call Anthem at 1-866-926-7789.

MAJOR COMPONENTS OF THE ANTHEM OPEN ACCESS UTILIZATION REVIEW/CASE MANAGEMENT

- The UR/CM program covers all City non-Medicare Retirees, Disability Retirees, Surviving Spouses, COBRA enrollees and all dependents for which the City's Basic Plan is prime.
- The UR/CM program requires pre-authorization for all inpatient hospital admissions (and emergency hospital admissions within 48 hours of the admission).
- **A PENALTY MAY BE IMPOSED IF ANTHEM OPEN ACCESS IS NOT NOTIFIED ON A TIMELY BASIS.**
- The additional UR/CM services include Continued Stay Review (monitoring of your continued treatment to assure that it is not longer than medically necessary), Second Surgical Review and Discharge Planning.
- The UR/CM program does not apply to City Retirees with Medicare.

Basic Plan Drug Benefits (Non-Medicare)

- Navitus is your Prescription Benefit Manager.
- You will have a ***Drug*** card from Navitus Health Solutions.
- You will have a 20% co-insurance for all your drugs.
- You will not have a formulary. You may have drugs that require prior authorization.
- For more information, call Navitus Health Solutions at 1-866-333-2757.

Basic Plan Drug Benefits (Medicare)

- DeanCareRx Medicare Part D is your Prescription Benefit Manager.
- You will have a card from DeanCareRx.
- You will have no more than a 20% co-insurance.
- During the Medicare contribution period, when the total cost of your drugs is over $310 and is less than $2840 (2011 Medicare limits) and the drugs you use are on the Medicare formulary, you will have a 5% co-insurance.
- During other periods you will have a 20% co-insurance.
- The Medicare Part D program has reduced your monthly premium.
- For more information, call DeanCareRx at 1-888-422-3326.

FAQ Basic Plan, NO MEDICARE, Navitus

Who are the Prescription Benefit Manager (PBM) and what name should be on my card?

- Navitus Health Solutions is your PBM and their name is on your card.

What is my cost for drugs?

- With the Basic plan you will have a 20% co-insurance for all your drugs.

Can I get a 90 day supply of maintenance medications?

- Yes, you can use the Navitus mail order or home delivery to get a 90 day supply of your maintenance medications.
- You will also pay 1/3 less since you will get a 90 day supply for a 60 day co-insurance.
- Prescription Solutions phone: 1-800-908-9097

May I continue to use my own pharmacy?

- Yes, as long as your pharmacy is a Navitus participating network pharmacy.
- Most pharmacies accept the Navitus card and are in their network.

Am I required to use generic medications?

- No, with the Basic Plan you do not have a formulary.
- There is a preferred drug list you can review on-line at www.navitus.com.
- There are significant savings to you if you and your doctor can identify a generic or lower cost medication since you are paying 20% of the cost.

Are there other ways I can save on my drug costs?

- Yes you can talk to Navitus about their pill splitting, use of certain over-the-counter drugs, use of generic and lower-cost brand name drugs, or use of mail order.

FAQ Basic Plan WITH MEDICARE, DeanCareRx Medicare D

Who are the Prescription Benefit Manager (PBM) and what name should be on my card?

- DeanCareRx is your PBM and their name is on your card.
- This is a Medicare Part D drug plan. Navitus Health Solutions provides a “wrap” plan so that the cost never exceeds 20%.

What is my cost for drugs?

- With the Basic plan through DeanCareRx you will have no more than a 20% co-insurance for all your drugs.
- After the total costs of your Medicare Part D formulary drugs exceeds $310 and until the total cost of your Medicare Part D formulary drugs reaches $2840 you will pay only 5% of the cost, since Medicare is paying 75%, and the Navitus wrap plan pays 20%.

Can I get a 90 day supply of maintenance medications?

- Yes, you can use Prescription Solutions, the Navitus/DeanCareRx mail order – or home delivery -- partner, to get a 90 day supply of your maintenance medications. Some local pharmacies will also provide 90 day supply.
- As a Medicare retiree you will also pay 1/3 less since you will get a 90 day supply for a 60 day co-insurance.
- Prescription Solutions phone: 1-800-908-9097.

May I continue to use my own pharmacy?

- Yes, as long as your pharmacy accepts the DeanCareRx card.

- Most pharmacies accept the DeanCareRx card.

Am I required to use generic medications?

- No, with the Basic Plan and DeanCareRx you do not have a formulary.
- There is a preferred drug list you can review on-line at www.navitus.com.
- The Medicare Part D plan also has a formulary.
- There are significant savings to you if you and your doctor can identify a generic or lower cost medication since you are paying 20% of the cost.

Are there other ways I can save on my drug costs?

- Yes, you can talk to DeanCareRx about their pill splitting, use of certain over-the-counter drugs, use of generic and lower-cost brand name drugs, or use of mail order.

When does Medicare make contributions towards my drug costs?

Below is a summary of your share:

- 20% co-pay for first $310 in **total drug costs** (your 20%, City 80%, and Medicare pays 0%).
- 5% co-pay for total drug costs from $310 to $2,840 (Medicare pays 75%, wrap plan pays 20%).
- 20% co-pay for total drug costs over $2,840 until **your out of pocket costs reach $4,550** (Medicare pays 0%).
- 1% co-pay after **your total out of pocket drug costs have reached $4,550** (Medicare pays 95%, wrap plan pays 4%).

How are Diabetic supplies covered?

- Most diabetic supplies are covered by DeanCareRx. See pg. 14 for additional information.

City of Milwaukee UnitedHealthcare CHOICE PLAN:

The City insured plan is administered by UnitedHealthcare Their phone number during open enrollment is 1-866-873-3903.

- The Choice Plan provides the same uniform City benefit structure as past HMO plans have provided.
- The Choice Plan has a national network that in 2011 will include a total of 520,000 in-network providers and 4,700 hospitals throughout the United States.
- A retiree outside of SE WI can enroll in the Choice Plan in 2011 and select a UnitedHealthcare provider and hospital outside of SE WI.
- Retirees enrolling in the Choice Plan in 2011 will not need to select a primary care physician.
- If your provider leaves the Choice Plan before the end of the plan year, you must see a new provider offered by the Choice Plan. The City cannot guarantee that a provider will be with the Choice Plan for the entire year. Physician contracts are established throughout the year, so any physician may choose not to continue with the contract at the renewal date.

You will be able to go to any UnitedHealthcare provider network in the United States. Be sure to check that the doctor and hospital you want are in the Choice Plan network before you finalize your selection. You can do this by calling UnitedHealthcare at 1-866-873-3903, or by going to the internet at www.UHC.com.

Non-Medicare Retiree Drug Benefits with UHC Choice Plan

- Navitus Health Solutions is your Prescription Benefit Manager.
- You will have the Navitus Health Solutions three-tier formulary with $5, $17 and $25 co-pay based on Navitus Drug Formulary.
- Some non-formulary drugs are not covered unless your physician completes and has approved an exception to the formulary.
- You can get a 90 day supply of maintenance drugs for a two-month co-pay through Prescription Solutions, only. Please contact them at 1-800-908-9097.
- For more information please contact Navitus Health Solutions at 1-866-333-2757.

Medicare Retiree Drug Benefits with UnitedHealthcare Choice Plan

- DeanCareRx, a Medicare Part D plan, is your prescription benefit manager.
- You will have $5, $17 and $25 co-pay based on DeanCareRx Drug Formulary.
- Some non-formulary drugs are not covered, unless your physician completes and has approved an exception to the formulary.
- Some drugs that are not on the "three-tier" formulary but are part of a Medicare Part D formulary will be covered but the member will have a 25% co-insurance only after their first $310 in drug costs but before their total drug costs reach $2840.
- You can get a 90 day supply of maintenance drugs for a two-month co-pay through Prescription Solutions or some local pharmacies, call Prescription Solutions at 1-800-908-9097.
- For more information please contact DeanCareRx at 1-888-422-3326.

FAQ for those with the Choice Plan and NO MEDICARE

Who are the Prescription Benefit Manager (PBM) and what name should be on my card?

- Navitus Health Solutions is your PBM and their name is on your card.

What is my cost for drugs?

- The UnitedHealthcare Choice Plan has a 3-tier formulary of $5, $17, $25 co-pay for drugs.
- Some non-formulary medications are not covered.

Can I get a 90 day supply of maintenance medications?

- Yes, you can use the Navitus mail order – or home delivery -- partner, Prescription Solutions to get a 90 day supply of your maintenance medications.
- You have a 3-tier formulary $10, $34 or $50 for mail ordered drugs.
- Prescription Solutions phone: 1-800-908-9097

May I continue to use my own pharmacy?

- Yes, as long as your pharmacy is a Navitus Health Solutions participating network pharmacy.
- Most pharmacies accept the Navitus Health Solutions card and are in their network.

Am I required to use generic medications?

- No, with the Choice plan you do have a three-tier formulary that requires you to use a drug on Tier 1, Tier 2 or Tier 3.

- There is a copy of the three-tier formulary or list of drugs you can review on-line at www.navitus.com.
- You can also contact Navitus at 1-866-333-2757 to see if your medications are on the formulary.

Are there other ways I can save on my drug costs?

- Yes you can talk to Navitus about their pill splitting, use of certain over-the-counter drugs, use of generic and lower-cost brand name drugs, and mail order.

City of Milwaukee United Healthcare Group Medicare Advantage (PPO) Plan

(replaces the SecureHorizons® MedicareDirect℠ Retiree Plan (Direct Plan)

The PPO Plan is only available to those who are "one person with Medicare" or "two persons with Medicare." The benefits are essentially the same as the Choice Plan benefits with the exception of the durable medical equipment benefit and the addition of a dental plan and the SilverSneakers Program. This is a national PPO plan that allows you access to a national contracted network. Please note that this plan requires a separate written notification of cancellation at least 30 days in advance

Medicare Retiree Drug Benefits with UHC PPO Plan

- You will have DeanCareRx Medicare Part D as your prescription benefit manager.
- You will have $5, $17 and $25 co-pay based on DeanCareRx formulary brand drugs.
- Some non-formulary drugs are not covered, unless your physician completes and has approved an exception to the formulary.
- You can get a 90 day supply of maintenance drugs for a two-month co-pay. Call Prescription Solutions at 1-800-908-9097.
- For more information please contact DeanCareRx at 1-888-422-3326.
- If you terminate your health enrollment, you must submit a written notice to UnitedHealthcare PPO. In order to complete your disenrollment, please either fax or send in this completed notice to: UnitedHealthcare, P.O. Box 29675, Hot Springs, AR 71903-9675; or Fax To: 1-800-891-8034.

FAQ for those with the UnitedHealthcare PPO Plan or the Choice Plan WITH MEDICARE

Who are the Prescription Benefit Manager (PBM) and what name should be on my card?

- DeanCareRx is your PBM and their name is on your card.
- This is a Medicare Part D drug plan.
- Navitus Health Solutions provides a "wrap" plan so that the cost for medications are $5, $17 $25.

What is my cost for drugs?

- With the UnitedHealthcare Choice Plan or the UnitedHealthcare PPO plan through DeanCareRx you will pay $5, $17, and $25 for drugs.
- Some non-formulary drugs are not covered.
- Some non-formulary drugs that are not covered may be on the Medicare Part D formulary and will be available for a 25% co-insurance amount after your total drug spend reaches $310 and until the total drug spend reaches $2840.

- For information about the three-tier formulary you can go to www.navitus.com or you can call DeanCareRx at 1-888-422-3326.

Can I get a 90 day supply of maintenance medications?

- Yes, you can use the Navitus mail order or home delivery partner, to get a 90 day supply of your formulary maintenance medications.
- You will have a 3-tier co-pay of $10, $34 or $50.
- Prescription Solutions phone: 1-800-908-9097

May I continue to use my own pharmacy?

- Yes, you may as long as your pharmacy accepts your DeanCareRx card.
- Most pharmacies accept the DeanCareRx card and are in their network.

Am I required to use generic medications?

- No, you are not required to use generic medications. With the UnitedHealthcare Choice Health Plan and the UHC Group Medicare Advantage (PPO) Plan *(replaces SecureHorizons MedicareDirect retiree plan)* and DeanCareRx, you will have a 3-tier co-pay.
- You can review the three-tier formulary on-line at www.navitus.com.
- The Medicare Part D plan also has a formulary.

Are there other ways I can save on my drug costs?

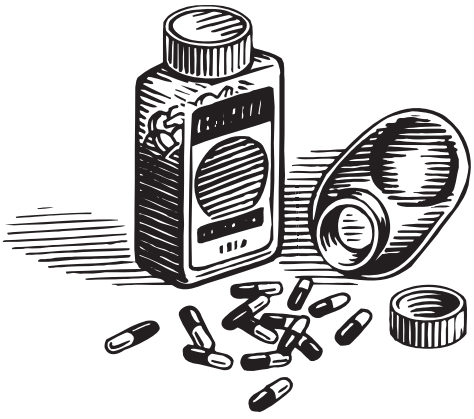
- Yes you can talk to Navitus about their pill splitting, use of certain over-the-counter drugs, use of lower-cost generic and brand name drugs and mail order.

If I use a non-formulary drug that is not on the Tier 3 formulary is there a process for getting an exception to the formulary?

- Yes, you can call DeanCareRx and they can send your doctor an exception to the formulary form.
- DeanCareRx will make the final decision regarding exceptions to the formulary.

How are Diabetic supplies covered?

- Most diabetic supplies are covered by DeanCareRx. See pg. 14 for additional information.



City of Milwaukee Diabetic Benefits for Retirees

Diabetic Claims (Equipment and Supplies) Claims Adjudication Processes

Non-Medicare Retirees	
Item	**Claim Adjudication**
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps.	Processed through the medical benefit • UnitedHealthcare **Choice**: processed at 100% through in-network DME provider • **Basic Plan** administered by Anthem processed at 80% of usual and customary costs through any DME provider
Diabetic testing supplies to include test strips, meters, lancets, etc.	Processed through the pharmacy benefit (Navitus). • UnitedHealthcare Choice Members have a three tier drug plan, $5, $17, $25 through Navitus. • Basic Plan Members administered by Anthem have a 20% co-insurance through Navitus Meters are available at no charge to the member.

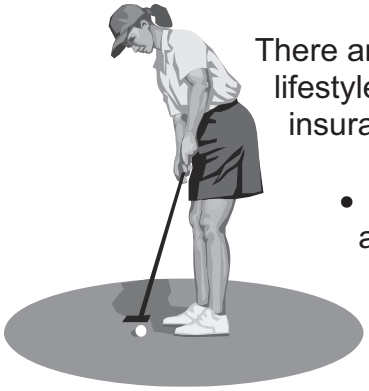
Medicare Retirees	
Item	**Claim Adjudication**
Durable Medical Equipment (DME) to include insulin pumps and the supplies used for insulin pumps.	Processed through the medical benefit • **Basic Plan**: Medicare Part B pays 80% and goes first; balance of 20% is paid by Anthem after Medicare B pays. • UnitedHealthcare **Choice**: Medicare Part B pays 80% and the balance of 20% is paid by UHC after Medicare B pays. • UnitedHealthcare **PPO**: Member has a 20% co-insurance for all DME items
Diabetic testing supplies to include test strips, meters, lancets etc.	Processed through Medicare B as primary for those with Basic Plan administered by Anthem and UnitedHealthcare Choice plan. The wrap portion of coverage is secondary. Medicare B pays 80%, the wrap portion pays the remaining 20%. • If Medicare B pays on the claim, the member has no copayment under the secondary coverage (wrap). • If Medicare B does not pay on the claim, the member is responsible for the applicable copayment under the secondary coverage (wrap). • Those with UnitedHealthcare PPO will have a three-tier co-pay since Medicare B does not pay, only DeanCareRx. **Note:** Some pharmacies will submit to both Medicare B and the secondary coverage electronically. Some pharmacies will only submit one claim to Medicare B and the member would then be responsible to submit the remaining balance to DeanCareRx to pay secondary.

Hospital Quality

The City understands the value of hospitals providing a high quality of care. There are several measures available for review of hospital quality. All the Milwaukee area hospitals are participating in quality assurance programs called the Leapfrog program and the Wisconsin Hospital Association Checkpoint plan. For more information about:

- Leapfrog hospitals data in WI, visit www.leapfroggroup.org/.
- WHA checkpoint data visit www.wicheckpoint.org click on, Reports, and then to South East Wisconsin hospitals.
- For quality information see Wisconsin Collaborative for Health Care Quality, www.wchq.org.

Healthy Links:



There are many helpful links on the internet that can help you maintain a healthy lifestyle. Among the sample of sites listed are sites from government, hospitals and insurance companies:

- A Healthier US Starts Here: www.mymedicare.com then go to “my Medicare” and “A Healthier US starts here” for information on prevention and wellness services available to all Medicare members.
  - Safety & Wellness tips www.os.dhhs.gov
  - Smoking cessation www.covhealth.org
- Wellness Walking Program www.froedtert.com
- Heart Care www.columbia-stmarys.org
- WI Governor’s Challenge www.wisconsinchallenge.org
- Physical activity to maintain good health www.aurorahealthcare.org/services/business/getmoving/index.asp
- UnitedHealthcare (UnitedHealthcare Choice Plan) site: www.uhc.com/ includes information about wellness services available to all UnitedHealthcare Choice Plan members
- Anthem BlueCross/BlueShield: www.Anthem.com for information on preventative care, healthy living and other resources.

NOTICES

- **Notice for all Medicare Retirees, Medicare dependents or Medicare family members to select both Part A and Part B of Medicare:**
  Retirees eligible for Medicare as a result of a disability and who are under 65 must select Medicare Part A & B. This is a requirement of all health plans offered by the City.

- **Notice for all Medicare Retirees, Medicare dependents or Medicare family members:**
  All City enrollees with Medicare are automatically enrolled in the DeanCareRx Medicare D Drug Plan.

- **No application should ever be mailed directly to the health plan**.
  See complete instructions on the health enrollment form.

- **Notice to Retirees Regarding the Thirty-Day Rule:**
  Retired employees are responsible for keeping their enrollment status current - notifying the Employee Retirement System **within 30 days** of births, adoptions, marriages, divorces, dependents ceasing to be dependents, former dependents that become eligible dependents again, deaths and **Medicare coverage**. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) **There will be no exceptions to this rule.**

- **Notice to Retirees regarding the One-Family Plan Rule**:
  - ❖ City retirees who are married to each other may only carry one health plan between them.
  - ❖ You are required to report your marriage to another city retiree within 30 days of the date of your marriage.
  - ❖ There may be financial penalties if you fail to report your marriage.

- **Notice to Retirees with Other Health Coverage**:
  - ❖ Retirees with other coverage through their own employment or their spouse's employment or retirement must choose one plan.
  - ❖ There is no penalty for a City retiree who waives coverage and enrolls for coverage through a spouse or another health plan.
  - ❖ When a retiree looses other coverage they can re-enroll with City retiree coverage.

* **Notice to Fire and Police Retirees**: your deductions can be taken pre-tax; contact ERS at (414)286-3557 for more information.

Something to Remember

We strongly recommend that you review the benefits and cost to you of the various plans offered. Call the plans directly for more information, or attend one of the information fairs listed on page 6. Remember, if you do not intend to make a change from your 2011 Basic Plan or Choice Plan, **you do not have to do anything**. If you are enrolled in the SecureHorizons MedicareDirect Plan in 2010, you will automatically be transitioned to the UnitedHealthcare PPO Plan in 2011. Changes to a different health plan will require you to complete a health enrollment application. See instructions on page 32.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE:These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. Benefits are always subject to medical necessity.

BENEFIT	City of Milwaukee **BASIC PLAN** **(Administered by Anthem Blue Cross Blue Shield).** **Services may be subject to Utilization Review for medical necessity.**	Uniform Benefit Plan **CHOICE PLAN** **UnitedHealthcare Choice Plan** ***Be sure to check with*** UnitedHealthcare ***to determine if specific treatments are covered.***	United Healthcare Group Medicare Advantage **UnitedHealthcare PPO PLAN** **UnitedHealthcare** ***Be sure to check with*** UnitedHealthcare ***PPO Retiree Plan to determine if specific treatments are covered.***
1. Hospitalization	100% of usual & customary charges covered. Additional benefits may be available under Major Medical.	Benefit is 100%.	Member has $0 co-payment or co-insurance for outpatient hospitalization services including observation, medical and surgical care.
2. Surgical Medical Care	100% of usual & customary charges of physician.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
3. Physician visits in Hospital	100% of usual & customary charges covered.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
4. Maternity	Semi-private hospital room charges paid. Pays usual & customary charges of physician (dependent daughters covered).	Benefit is 100%.	No maternity benefit.
5. X-Ray and Lab Tests (including Routine)	100% of usual & customary charges covered.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
6. Radiation Therapy	100% of usual & customary charges covered.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
7. Emergency Room **A. Accident (in or out of area)** **B. Illness (in or out of area)**	100% of usual & customary charges covered. No maximum. If final diagnosis indicates such treatment was necessary-usual & customary charges covered.	Member has $50 Emergency Room Co-pay for accident or illness.	Member has a $50 Emergency Room co-payment for accident or illness.
8. Physician Office Visit & Urgent Care Services	Covered at 80% usual & customary charges under major medical after deductible is satisfied	Member has a $10 co-pay for all office and urgent care visits due to illness or injury.	Member has a $10 co-payment for all office and urgent care visits due to illness or injury.
9. Major Medical Care **A. Yearly Deductible** **B. Coinsurance/Co-payment**	$50(retiree) per person - $150 family maximum. 80% Covered, 20% paid by subscriber.	NONE Applicable as noted next to benefit	NONE Applicable as noted next to each benefit.
10. Chiropractor Office Visits	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
11. Physical Therapy, Speech Therapy & Occupational Therapy	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is payable for up to 50 visits per calendar year for **EACH** type of medically necessary therapy.	Member has $0 co-payment or co-insurance per visit.
12. Immunizations & Injections	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is payable for medically necessary injections or immunizations, including hormones.	Member has $0 co-payment or co-insurance per visit.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE:These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. Benefits are always subject to medical necessity.

BENEFIT	City of Milwaukee **BASIC PLAN** **(Administered by Anthem Blue Cross Blue Shield).** **Services may be subject to Utilization Review for medical necessity.**	Uniform Benefit Plan **CHOICE PLAN** **UnitedHealthcare Choice Plan** ***Be sure to check with*** UnitedHealthcare ***to determine if specific treatments are covered.***	United Healthcare Group Medicare Advantage **UnitedHealthcare PPO PLAN** **UnitedHealthcare** ***Be sure to check with*** UnitedHealthcare ***PPO Retiree Plan to determine if specific treatments are covered.***
13. Durable Medical Equipment	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit includes 20% co-insurance, up to a maximum of $500 per member per calendar year for durable medical equipment, prosthetics and orthotics combined. Covered services include, but are not limited to, the initial acquisition of artificial limbs and eyes, cast, splints, trusses, crutches, orthopedic braces and appliances, ostomy supplies, compression hose for appropriate diagnoses, wheelchairs, hospital type beds, and artificial respiration equipment, therapeutic lenses, and initial cataract lenses.	Member has 20% co-insurance for each Medicare-covered item.
14. Prescription Coverage (including oral contraceptives)	**Retail** Covered at 80% under major medical for a 30-day supply. A select list of over-the-counter (OTC) medications are covered within the Navitus formulary. Additionally, the following four OTCS are covered as well; Zyrtec (cetirizine), Claritin (loratadine), Alavert, and Niacin. **Mail Order** For additional savings, Prescription Solutions Mail Order will provide a three months (90 days) supply for a two months (60days) coinsurance on most maintenance drugs. There is no out of pocket maximum for retail or mail order prescription drugs. ***Prescription Coverage is administered by Navitus Health Solutions for Non-Medicare retirees and by DeanCareRx for Medicare retirees.***	There is a three-tier drug plan. Tier 1 drugs have a $5 co-pay. Tier 2 drugs have a $17 co-pay and Tier 3 drugs have a $25 co-pay. A select list of over-the-counter (OTC) medications are covered within the Navitus formulary. Additionally, the following four OTCS are covered as well; Zyrtec (cetirizine), Claritin (loratadine), Alavert, and Niacin. There are non-covered drugs that are on the three tier formulary. **Mail Order** For additional savings, Prescription Solutions Mail Order will provide a three months (90 days) supply for a two months (60day) co-pay on most maintenance drugs. Please see the FAQ section for additional information regarding prescription drugs. ***Prescription Coverage is administered by Navitus Health Solutions for Non-Medicare retirees and by DeanCareRx for Medicare retirees.***	There is a three-tier drug formulary: $5 co-pay for generic drugs, $17 co-pay for formulary brand drugs and $25 for non-formulary drugs. A select list of over-the-counter (OTC) medications are covered within the Navitus formulary. Additionally, the following four OTCS are covered as well; Zyrtec (cetirizine), Claritin (loratadine), Alavert, and Niacin. **Mail Order** For additional savings, Prescription Solutions Mail Order will provide a three months (90 days) supply for a two months (60days) coinsurance on most maintenance drugs. Please review www.deancare.com/deancarerx/ for the complete three tier formulary listing. Please see the FAQ section for additional information regarding prescription drugs. ***Prescription Coverage administered by DeanCareRx.***
15. Allergy Care	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE:These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. Benefits are always subject to medical necessity.

BENEFIT	City of Milwaukee BASIC PLAN (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	Uniform Benefit Plan CHOICE PLAN UnitedHealthcare Choice Plan *Be sure to check with* UnitedHealthcare *to determine if specific treatments are covered.*	United Healthcare Group Medicare Advantage UnitedHealthcare PPO PLAN UnitedHealthcare *Be sure to check with* UnitedHealthcare *PPO Retiree Plan to determine if specific treatments are covered.*
16. Mental Health and Substance Abuse, Drug and Alcohol Abuse	Benefit includes outpatient hospital services, inpatient hospital services and transitional care as medically necessary. Professional office visits covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit includes outpatient hospital services, inpatient hospital services and transitional care as medically necessary. Member has a $10 co-pay for professional office visits.	Member has $0 co-payment or co-insurance per visit for outpatient mental health care and for outpatient substance abuse services. Member has $0 co-payment or co-insurance per admission, 190 days lifetime maximum. Member has $0 co-payment or co-insurance per day for partial hospitalization psychiatric program.
17. Organ Transplants	All non-experimental and non-investigational care related to transplant is covered as limited by the plan, including donor searches/procurements and private duty nursing.	Benefit is 100% when the United Resource Network (URN) Organ Transplant Network is utilized. Drug co-pays apply for transplant related drugs. Covers heart, heart/lung, liver, lung, kidney, kidney/pancreas, bone marrow, parathyroid, and musculo/skeletal.	Member has $0 co-payment or co-insurance for medically necessary organ transplants.
18. Ambulance	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit for surface ambulance is payable in full for first $300; charges in excess of $300 payable at 80%. Benefit for air ambulance is payable in full for first $1,000; charges in excess of $1,000 are payable at 80%. **Co-insurance is waived for UHC approved hospital-to-hospital transfers.**	Member has 20% co-insurance for all ambulance services. ***Co-insurance is waived for approved hospital-to-hospital transfers.***
19. Private Duty Nursing	Covered at 80% usual & customary under major medical after deductible is satisfied	Benefit for Home Health Care is limited to 50 visits per calendar year.	Please refer to Home Health Care #32.
20. Oral Surgery	*13 specific oral surgical procedures provided, including gingivectomy, alveolectomy & apicoectomy covered at 80% usual & customary charges under major medical after deductible is satisfied	Benefit is limited to *13 specific oral surgical procedures, including gingivectomy, alveolectomy & apicoectomy.	Member has $0 co-payment or co-insurance for each Medicare-covered dental service. Also includes a basic dental plan subject to an annual $50 deductible then provides 100% for preventive, 80% for basic and 50% for major services $1000 annual limit. Please contact UHC PPO Plan for additional dental services at 1-800-610-2660.
21. TMJ Treatment	Covered at 80% usual & customary charges under major medical after deductible is satisfied.	Benefit is limited to 80% of charges related to diagnosis and treatment of TMJ dysfunction syndrome for the following: - Physician and specialist consultation - rehabilitative therapy services including TENS therapy	Member has $0 co-payment or co-insurance for each Medicare-covered dental service. Also includes a basic dental plan subject to an annual $50 deductible then provides 100% for preventive, 80% for basic and 50% for major services $1000 annual limit.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE:These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. Benefits are always subject to medical necessity.

BENEFIT	City of Milwaukee BASIC PLAN (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	Uniform Benefit Plan CHOICE PLAN UnitedHealthcare Choice Plan *Be sure to check with* UnitedHealthcare *to determine if specific treatments are covered.*	United Healthcare Group Medicare Advantage UnitedHealthcare PPO PLAN UnitedHealthcare *Be sure to check with* UnitedHealthcare *PPO Retiree Plan to determine if specific treatments are covered.*
		- adjustment of corrective appliances - charges for the fitting and installation of corrective splints.	Please contact UHC PPO Plan for additional dental services at 1-800-610-2660.
22. Skilled Nursing Home Care (after hospitalization)	30 days per disability under basic benefits at 100%. An additional 90 days under major medical benefits at 80% usual & customary charges after the deductible is satisfied.	Benefit for skilled nursing care is for a maximum of 120 days per inpatient stay.	Member has $0 co-payment or co-insurance for days 1-100, up to 100 days per benefit period; three-day prior hospital stay is not required.
23. Hospice Care	COVERED at 100%.	Benefit for Hospital hospice or home hospice care covered, depending on the decision of the individual's primary care physician. Benefit is 100%.	Member has $0 co-payment or co-insurance per visit.
24. Vision Care	NOT COVERED	Benefit is for routine vision care annual exam including the prescription of eyewear at UHC network facility only. No coverage for eyeglasses or contact lenses. Discounts for eyeglasses or contact lenses are available under the UHC STANDARD VISION Program at 1-877-426-9300.	Member has $0 co-payment or co-insurance for each Medicare-covered eye examination. Member has $75 allowance for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. Member has $10 co-payment for each refractive eye examination limited to one examination per calendar year for routine vision services.
25. Physicians' Charges for Preventive Care Services including Well Baby Care	Well Baby Care Visits covered at 100%, all other charges covered at 80% usual & customary charges.	Benefit is 100%.	Member has $0 co-payment or co-insurance for preventive care services, the office visit co-payment may apply.
26. Hearing Exams	Covered at 80% usual & customary under major medical after deductible is satisfied, when there is a medical condition (not for the purpose of prescribing hearing aids).	Benefit is covered only if performed by primary care physician or approved specialty physician.	Member has $0 co-payment or co-insurance per visit for Medicare-covered diagnostic hearing examination.
27. Hearing Aids	For enrolled dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law.	For enrolled dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law.	NOT COVERED.
28. Nutritional Counseling	Nutritional counseling for the treatment of morbid obesity is covered at 80% usual & customary under major medical after deductible is satisfied.	Benefit is covered when medically necessary. Benefit is 100%.	Member has $0 co-payment or co-insurance for medically necessary nutritional counseling.
29. Infertility Services (Diagnosis of Infertility)	NOT COVERED. Diagnostic services covered at 80% under major medical after deductible is satisfied, only. Treatment and prescription	No benefits for services primarily for the purpose of treating or reversing infertility or for artificial insemination services including donor service or	NOT COVERED.

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE:These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts. Benefits are always subject to medical necessity.

BENEFIT	City of Milwaukee BASIC PLAN (Administered by Anthem Blue Cross Blue Shield). Services may be subject to Utilization Review for medical necessity.	Uniform Benefit Plan CHOICE PLAN UnitedHealthcare Choice Plan *Be sure to check with* UnitedHealthcare *to determine if specific treatments are covered.*	United Healthcare Group Medicare Advantage UnitedHealthcare PPO PLAN UnitedHealthcare *Be sure to check with* UnitedHealthcare *PPO Retiree Plan to determine if specific treatments are covered.*
	drugs are not covered.	other forms of fertilization including prescription drugs for infertility.	
30. Physical Fitness	NOT COVERED	NOT COVERED	SilverSneakers® Fitness Program included.
31. Home Health Care	Up to 40 visits per year when medically necessary under basic benefits. An additional 40 days covered at 80% under major medical per calendar year after the deductible is satisfied.	Benefit for home health care is limited to 50 visits per year.	Member has $0 co-payment or co-insurance per visit.
32. Dependent Coverage	Include employee's spouse; eligible dependent children, stepchildren, foster children, grandchildren (if the parent is an eligible dependent child under the age of 18), adopted children and children placed for adoption as mandated by the State or Federal government. Based on the recent federal health care reform, coverage for dependent children is through the end of the calendar year in which the dependent child or adult child turns 26, without regard to the adult child's school status, marital status or dependent status. There will be state imputed tax only, not federal imputed tax, if the adult child is not an IRS dependent. Based on current state law the adult child is eligible for coverage through the end of the month the child turns 27. If the adult child has turned 26 in the previous year the adult child can be covered until the end of the month they turn 27 but with both federal and state imputed tax.		
Policy Deductible	See #9 above	NONE	NONE
"UNIFORM BENEFITS" does not mean that each Health Plan option from year to year will treat all illnesses in the same manner. Nor does it require that each and every service be identically covered. UnitedHealthcare (UHC) Choice Plan retains the right to substitute services in such a manner as to maintain quality care of the patient. However, maximums, deductibles, co-pay amounts, or co-insurance specified in this document cannot be altered. Treatment will vary based on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan.			
The **"LIFETIME LIMIT"** on the dollar value of benefits under the Basic Plan administered by Anthem and the United Healthcare Choice Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the City of Milwaukee, Employee Benefits Division at 414-286-3184.			

*** UnitedHealthcare and Anthem Oral Surgery is limited to the following 13 oral surgical procedures (see #20 above):**

1. Surgical removal of bony impacted teeth;
2. Excision of tumors, cysts of the jaws, cheeks, lips, tongue, roof of mouth when such conditions require pathological examination;
3. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of mouth;
4. Apicoectomy;
5. Excision of exostosis of jaws and hard palate;
6. Treatment of fractures of facial bones;
7. External incisions and drainage of cellulitis;
8. Incision of accessory sinuses, salivary glands or ducts;
9. Gingivectomy;
10. Alveolectomy;
11. Frenectomy;
12. Removal of retained root;
13. Gingival and Apical curettage.

Simple.

Health plan benefits you can understand.

At UnitedHealthcare, we go the extra mile to make sure you can get the most out of your health care coverage. And part of that effort includes creating programs and options that are easy to understand, simple to use, and help make our plans work even better.

24-hour NurseLine℠ services make it easy to connect to the right care

- Help from a live registered nurse by phone anytime
- Get doctor and appointment recommendations with personal follow-ups
- See if the emergency room, a doctor visit or self-care is right for your needs
- Learn more about a diagnosis
- Search for doctors based on your needs and preferences
- Find hospitals that meet UnitedHealthcare's quality standards
- Explore the risks, benefits and possible outcomes of your treatment options
- Learn how to take medication safely and avoid interactions

For informational purposes only. NurseLine℠ nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time. For a complete description of the UnitedHealth Premium® Designation program, including details on the methodology used, geographic availability, program limitations and medical specialties participating, please see myuhc.com®.

It's never been easier to get quality care

We have high standards for the doctors in our network, anyway. But to recognize the doctors who have a proven track record for delivering quality care that keeps patients from needing further treatments – and to make sure our members can find them easily, we created the UnitedHealth Premium® designation program. It evaluates and recognizes physicians who meet national industry standards for quality care and local market benchmarks for cost efficiency.

Visit myuhc.com® to begin your search. All you have to do is look for the stars.

Step 1: Go to myuhc.com.
Step 2: Click Find a Physician or Facility.
Step 3: Select Search for a Physician and click Continue.
Step 4: Select Search for UnitedHealth Premium Physician and fill out your name/location/plan. Click Continue.
Step 5: Select any specialties you need. Click Continue.
Step 6: Browse the list to find the 2-star doctor best suited to your needs.

The simplest solution of all: creating plans packed with value and quality

To make it even easier for you to pick a plan that works for you, all of our plans are packed with the right combination of benefits, value, options and extras. Suddenly, shopping for health care coverage just got simpler.

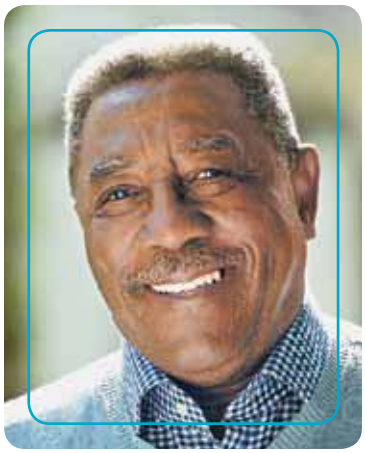
UnitedHealthcare®
Healing health care. Together.®

Be there for the people you care about

For Open Enrollment questions, please call 1-866-926-7789

www.anthem.com

Anthem



City of Milwaukee

A UnitedHealthcare® Group Medicare Advantage (PPO) plan may be the right plan for you.

This plan gives City of Milwaukee retirees more benefits and services than Original Medicare.

Our wide range of products and programs gives you control of your health care needs.

City of Milwaukee retirees have access to the following services:

- **Evercare™ Solutions for Caregivers**
  This service is designed for members who provide care for a family member or are interested in care options for themselves.
- **Membership in a fitness program designed for seniors — at no additional cost.**
- **Access to registered nurses 24 hours a day.**
- **Health and well-being programs provided through OptumHealth.℠**

Questions?

Call Customer Service toll-free:
1-877-714-0178, TTY **711**
8 a.m. – 8 p.m. local time, 7 days a week

UnitedHealthcare®

A UnitedHealthcare® Medicare Solution

The benefit information provided herein is a brief summary, not a comprehensive description of benefits. For more information contact the plan.

UnitedHealthcare® Medicare Advantage plans are offered by UnitedHealthcare Insurance Company and its affiliated companies, Medicare Advantage Organizations with a Medicare contract. Limitations, copayments and coinsurance may apply. Benefits may vary by employer group.

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Lighting the way to better health

As the pharmacy benefit manager for the City of Milwaukee's Health Plans, Navitus Health Solutions is dedicated to providing the best possible care at the lowest possible cost. We light the way to better health by providing world-class customer service and offering programs and services aimed at supporting the health care needs of you and your family.

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans beginning with plan year anniversary dates after June 30, 1997. Other requirements apply beginning with plan year anniversary dates occurring on or after January 1, 1998. HIPAA provides that the plan sponsor of a self-funded nonfederal governmental plan may elect to exempt the plan from any or all of the following requirements:

1. **Limitations on preexisting condition exclusion periods**.
   A preexisting condition exclusion period may not exceed 12 months, and must be reduced, under certain circumstances, by prior medical benefits coverage an individual has had.
2. **Special enrollment periods**.
   Group health plans are required to provide a 30-day special enrollment period for individuals and dependents that do not enroll in the plan at the first opportunity because they have other coverage and subsequently lose that coverage. Also, if a plan provides dependent coverage and a person becomes a dependent through marriage, birth, adoption or placement for adoption, the plan must provide a special enrollment period of not less than 30 days.
3. **Prohibitions against discriminating against individual participants and beneficiaries based on health status**. A group health plan may not establish enrollment rules (including continued eligibility) for an individual based on any of the following health status-related factors:
   - medical condition (physical and mental illnesses)
   - claims experience
   - receipt of health care
   - medical history
   - genetic information
   - evidence of insurability
   - and disability
4. **Standards relating to benefits for mothers and newborns.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for mother and child for a minimum period of time, generally 48 hours for a normal vaginal delivery, and 96 hours for a cesarean section.
5. **Parity in the application of certain limits to mental health benefits.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering mental health benefits may not set annual or lifetime limits on mental health benefits that are lower than limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose a limit on mental health benefits. These requirements do not apply to benefits for substance abuse or chemical dependency.

The City of Milwaukee has elected to exempt its Basic Health Plan from all of the above requirements. The City of Milwaukee's Basic Health Plan currently voluntarily provides certain benefits similar to requirements 1, 2 (with respect to dependent coverage only), 3 and 4 above.

The exception from these Federal requirements will be in effect for the plan years beginning January 1, 2011 and ending December 31, 2012.

Any questions concerning this notice may be directed to:

Employee Benefits Director
200 E. Wells St.
City Hall, Room 706
Milwaukee, WI 53202
(414) 286-3184

This notice is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Important Information About Your COBRA continuation coverage Rights

What is continuation coverage?

Federal law requires that group health plans (including the City of Milwaukee Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including: open enrollment and special enrollment rights. Specific information describing continuation coverage can be obtained from the Employes' Retirement System, 789 North Water St., Suite 300, Milwaukee, WI 53202, 414-286-3557.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Milwaukee Employee Benefits of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the City of Milwaukee Employee Benefits of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the City of Milwaukee Employee Benefits of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the City of Milwaukee Employee Benefits within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law.

1. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap.
2. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.
3. Finally, you should take into account that you have special enrollment rights under federal law.
   a. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above.
   b. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

When and how must payment for continuation coverage be made?

1. First payment for continuation coverage

   If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

   Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the City of Milwaukee Employee Benefits to confirm the correct amount of your first payment.

Your first continuation coverage payment should be sent to:

Employes' Retirement System
789 North Water Street, Suite 300
Milwaukee, WI 53202

2. Periodic payments for continuation coverage

   After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic continuation coverage payments should be sent to:

Employes' Retirement System
789 North Water Street, Suite 300
Milwaukee, WI 53202

3. Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days *[or enter longer period permitted by Plan]* to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Special Notice to All

Retirees and their Families

Women's Health and Cancer Right Act Notice
Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of mastectomy.

The City of Milwaukee health plans comply with these requirements. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The City of Milwaukee health plans do not impose penalties (for example, reducing or limiting reimbursements) and do not provide incentives to induce attending providers to provide care inconsistent with these requirements.

Questions, call the Employes' Retirement System at (414) 286-3557.

HOW TO ENROLL

ENROLLMENT FORMS

1) If you are making a change and need a health enrollment application, they will be available at the following locations:
   a) Health Carriers;
   b) Open Enrollment Fairs;
   c) Internet – www.milwaukee.gov/der;
   d) ERS Office, 789 North Water Street
   e) City Hall, Room 706.
2) If you add or delete a dependent(s):
   a) Complete a Health Enrollment Form,
   b) Write the name of the dependent in SECTION B of the Health Enrollment Form.
   c) Place a check (☑) in the appropriate box in SECTION C on the Health Enrollment Form.
3) **If you do not want health coverage, or wish to waive coverage contact the Health Insurance Specialist at ERS for an appropriate waiver form.** Note there is no penalty for a retiree who waives coverage and takes coverage through a spouse's health plan, other employment or a Medicare complete plan. If you waive coverage you cannot re-enroll until the next open enrollment, unless there is a qualifying event. Retirees must maintain coverage if they wish to re-enroll in a City plan at some future date.
4) **Retirees are not eligible for dental coverage, except with the Direct Plan.**
5) **Notice for all Medicare Retirees, Medicare dependents or Medicare family members to select both Part A and Part B of Medicare**: Retirees eligible for Medicare as a result of a disability and who are under 65 must select Medicare Part A & B. This is a requirement of all health plans.

If you are making a Health Plan Change for the Year 2011

1 . Write **"RETIREE"** in the **JOB TITLE** box of all enrollment forms.
2 . A COBRA enrollee will write "COBRA" in the JOB TITLE box.
3 . DO NOT write anything in the CITY START DATE and RETURN TO WORK DATE boxes.

If you are eligible for both parts of Medicare (Part A and Part B),

a . Please be certain to attach a photocopy of your Medicare I.D. card, and for your spouse if applicable, to your enrollment form.
b . Since coverage under Medicare usually reduces your monthly health insurance premium, it is important you make certain that we know of your Medicare coverage and that we are charging you the correct monthly health insurance premium.

All "RETIREE" applications should be returned to the office at the address below no later than 4:45 p.m. Friday, October 29, 2010:

City of Milwaukee
Employes' Retirement System
Suite 300
789 North Water Street
Milwaukee, WI 53202

Important Telephone Numbers & Websites

TELEPHONE NUMBERS	LOCAL	800#
Employes' Retirement System	414-286-3557	1-800-815-8418

Health Plan Telephone Numbers and Websites

BASIC PLAN (Anthem Blue Cross Blue Shield)	1-866-926-7789	www.Anthem.com
UnitedHealthcare Choice Plan	1-866-873-3903	www.myuhc.com
UnitedHealthcare Choice (Vision)	1-877-426-9300	www.uhcvision.com
UnitedHealthcare Group Medicare Advantage (PPO) Plan	1-800-610-2660	TTY: 711
PPO Plan Dental Information	1-800-610-2660	
PPO Silver Sneakers Information	1-800-610-2660	www.silversneakers.com
DeanCareRX (for Medicare retirees)	1-888-422-3326	www.deancarerx.com
Navitus Health Solutions (Pharmacy)	1-866-333-2757	www.Navitus.com
Prescription Solutions (Mail Order)	1-800-908-9097	www.PrescriptionSolutions.com

If you have any questions regarding your benefits, or regarding unpaid bills, or problems with service, please call your health plan. **DO NOT** call the ERS office until you have contacted your health plan and are unable to arrive at a resolution. ERS will attempt to assist you to resolve your problem, but in no case will ERS attempt to change, question or provide a medical opinion. Remember to document all your conversations with dates, times and names. We will ask you for this information when you call our office.